Commonwealth of Massachusetts

# Health Policy Commission

# CHART Phase 2: Implementation Plan Winchester Hospital

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Version: 4

# Introduction

This Implementation Plan details the scope and budget for Winchester Hospital's ("Contractor") Award in Phase 2 of the Health Policy Commission's (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. The Implementation Plan is incorporated by reference into and is subject to the requirements of the Phase 2 Award Contract, including the Phase 2 Terms & Conditions.

Many capitalized terms appearing in the Implementation Plan are defined in the Phase 2 Terms & Conditions or the Phase 2 Request for Proposals (RFP). In addition to capitalized terms, the Implementation Plan may include other acronyms and/or abbreviations whose meaning is understood by Contractor and the HPC in the context of the Implementation Plan. If there is disagreement concerning the meaning of a term, acronym, or abbreviation, the HPC's interpretation shall govern.

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# Key personnel

| Name | Title | CHART Phase 2 Role |
|---|---|---|
| Dale Lodge | Chief Executive Officer | Executive Sponsor |
| Richard Weiner, MD | Vice President for Medical Affairs | Clinical Investment Director |
| Kathy Schuler, RN, MSN | Vice President Patient Care Services and Chief Nursing Officer | Operational Investment Director |
| Mary Beth Strauss | Director, Quality & Patient Safety Magnet Program Director | Project Manager |
| Diane McCarthy | Financial Analyst | Financial Designee |

# Target population



**Definition***

**Target population 1**

- All high utilizers**

**Target population 2**

- All discharges to post-acute care (SNF and home health)

**Quantification**

3,832 discharges per year

**Target population 1:**

- 140 high utilizers with 696 discharges

**Target population 2:**

- 3,136 discharges to PAC

* Target population definition includes all payers and ages 18+; OB, deaths, transfers to acute inpatient care, and discharge to acute rehab.

** All patients with 4 or more inpatient hospitalizations in the past 12 months.

# Aim Statement



| Primary Aim Statement 1 |
| --- |
| Reduce 30-day readmissions by 20% for high utilizer patients by the end of the 24 month Measurement Period. |

| Primary Aim Statement 2 |
| --- |
| Reduce 30-day readmissions by 20% for all patients discharged to post-acute care by the end of the 24 month Measurement Period. |

| Secondary Aim Statement* |
| --- |
| Reduce 30-day ED returns by 10% for high utilizer patients by the end of the 24 month Measurement Period. |



*Your secondary aim statement is a performance measure only and is not tied to Achievement Payment.

# Baseline performed – Readmission reduction

| | | 14-Jan | 14-Feb | 14-Mar | 14-Apr | 14-May | 14-Jun | 14-Jul | 14-Aug | 14-Sep | 14-Oct | 14-Nov | 14-Dec | Avg. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital-Wide | Readmits | 76 | 55 | 78 | 93 | 70 | 79 | 81 | 72 | 77 | 64 | TBD | TBD | 75 |
| | D/c | 978 | 923 | 927 | 968 | 967 | 949 | 1024 | 962 | 963 | 960 | 896 | TBD | 956 |
| | Rate (%) | 7.77% | 5.96% | 8.41% | 9.61% | 7.24% | 8.32% | 7.91% | 7.48% | 8.00% | 6.67% | TBD | TBD | 7.79% |
| Post Acute Care Segment | Readmits | 42 | 33 | 41 | 51 | 41 | 30 | 32 | 21 | 42 | 32 | TBD | TBD | 37 |
| | D/c | 277 | 284 | 276 | 301 | 286 | 250 | 269 | 235 | 238 | 248 | 255 | TBD | 265 |
| | Rate (%) | 15.16% | 11.62% | 14.86% | 16.94% | 14.34% | 12.00% | 11.90% | 8.94% | 17.65% | 12.90% | TBD | TBD | 13.75% |

| | | Yr ending Jan 14 | Yr ending Feb 14 | Yr ending Mar 14 | Yr ending Apr 14 | Yr ending May 14 | Yr ending Jun 14 | Yr ending Jul 14 | Yr ending Aug 14 | Yr ending Sep 14 | Yr ending Oct 14 | Yr ending Nov 14 | Yr ending Dec 14 | Yrly Avg. | Month. Avg |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High Utilizer Segment | Readmits | 366 | 373 | 369 | 369 | 348 | 333 | 303 | 298 | 257 | 280 | TBD | TBD | 330 | 27 |
| | D/c | 828 | 830 | 813 | 803 | 764 | 759 | 710 | 708 | 696 | 663 | 595 | TBD | 743 | 62 |
| | Rate (%) | 44.20% | 44.94% | 45.39% | 45.95% | 45.55% | 43.87% | 42.68% | 42.09% | 36.93% | 42.23% | TBD | TBD | 44.4% | 44.4% |

# Estimated monthly impact



| | Current Expected Served | Current Expected Events | New Expected Avoided Events | New Expected Events |
|---|---|---|---|---|
| Reduce 30 day readmissions - Post Acute Care Population | 265 discharges per month served | 13.75% * 265 = 36 readmissions/month | 0.2*36 = 7 avoided readmissions | We expect 36-7 = 29 readmission per month among this segment |
| Reduce 30 day readmissions - High Utilizer Population | 62 discharges per month served | 44.38% * 62 = 27 readmissions/month | 0.2 * 27 = 5 avoided readmissions | We expect 27-5 = 22 readmissions among this segment |

# Driver Diagram

Reduce 30-day readmissions by 20% for high utilizers* and reduce 30-day readmissions by 20% for discharges to post acute-care by the end of the 24 month Measurement Period

## Improve cross-setting clinical collaboration to increase effectiveness of efforts to reduce avoidable readmissions.

- CCT will refer Target Population patients to Winchester Pharmacy for enhanced post-discharge education, delivery, bubble pack services
- Educate ED providers of SNF, LTAC capabilities and scope of services and develop direct PAC – ED communication to avert admissions
- Engage PAC (HH and SNF) in readmission reviews for all PAC readmits
- CCT will communicate care plan information to all relevant clinical and social providers via technology, warm handoffs and/or cross-setting care plan rounds
- Utilize complex care management plans by ED and Hospital staff, CCT members
- Coordinate behavioral health services with Lahey-Lowell joint initiative

## Deploy a cross-setting complex care team (CCT) to manage the patient in the post acute setting

CCT will comprise of a: nurse practitioner, pharmacist, community social worker, inpatient case manager, and a readmission prevention nurse. Other care team members (behavioral health, hospice, etc) as needed. The CCT will:

- Respond in real-time to Target Patient in ED, or call from PAC/community
- Lead intensive care planning/goals in ED or Inpatient settling
- Develop, manage and share individual care plans for all Target Pop patients
- Collaborate with Care Dimensions (pall care) to develop care plans
- High quality iterative medication optimization
- Conduct RCA for all readmissions among target population
- High-touch in person coordination in home and in PAC settings

## Leverage Technologies to expedite the identification and cross-setting management of high risk patients

- Flag all Target Pop. patients in ED as well as those d/c to PAC;
  Notify CCT in real-time of all ED/admissions of Target Population
- Leverage tech to track services delivered of CCT & outcomes weekly/mo.
- Develop system to share care plan with clinical and service providers; accessible in ED to facilitate decisions to avert admission





*High utilizers are defined as four or more discharges in the past 12 months. Target population definition includes all payers and aged 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab

# Service Model – High Utilizers

## Narrative description of your service model

Winchester Hospital will deploy a cross-setting complex care team (CCT) consisting of a nurse practitioner, pharmacist, community social worker, inpatient case manager, and readmission prevention nurse. Additional care providers (behavioral health, palliative care, PAF liaisons, etc.) will be utilized as needed. The CCT will work in collaboration with other members of the health care team to include medical staff, nursing staff, rehab services, home care liaison.

Patients within the high utilizer target population will be identified and assigned to the CCT upon admission. Within 24 hours of identification, the CCT will conduct initial care rounds which will include, but is not limited to medication reconciliation by a pharmacist, behavioral health consult if appropriate, case management assessment, and development of a care plan.

During the inpatient stay, the CCT will round routinely on this cohort of patients, will utilize the Care Dimensions liaison to facilitate consults for palliative and/or hospice care, will facilitate documentation of MOLST and Honoring Choices information and there will be an assessment done by a community based social worker. In addition, during the patient stay/prior to discharge, patients will be introduced to the Winchester Pharmacy community program which provides medication delivery, reconciliation, and education to patients in the community. Throughout the stay, the CCT will engage both the patient, family as appropriate and/or any identified key learners/support people. These individuals will be engaged in the development of the care plan and discharge plan.

At the time of/just prior to discharge any follow-up appointments needed will be scheduled by hospital staff and communicated to the patient/family as part of the discharge plan. A pharmacist will review all discharge medications and make any needed recommendations. The NP will give the community PCP and/or SNFist a warm hand-off.

Follow up phone calls will be made within 24 hours of discharge. Based on the needs of the patient, the NP and/or the readmission prevention nurse will visit the complex care patient at home. The community social worker, based on the needs of the patient, will visit the patient within 3-5 days and assess for social agency supports needed.

# Service Model – Discharges to Post Acute Care Facilities

## Narrative description of your service model

Patients within the second target population (discharges to PAC) will be identified and assigned to the CCT after admission, upon knowing their discharge disposition. Winchester Hospital will then deploy a cross-setting complex care team (CCT) consisting of a nurse practitioner, pharmacist, community social worker, inpatient case manager, and readmission prevention nurse to insure a smooth transition to the next level of care.

Additional care providers (behavioral health, palliative care, PAF liaisons, etc.) will be utilized as needed. The CCT will work in collaboration with other members of the health care team to include medical staff, nursing staff, rehab services, home care liaison.

Services will be provided based upon the needs of the patient. At minimum, all patients will have a warm hand-off to the post discharge facility at time of discharge. As their needs become more complex, the services post discharge will become more intense (tiered services). The CCT will maintain contact with the patient/family while being cared for in the post acute setting.

The NP, readmission prevention nurse and/or community social worker will participate in the discharge plan and advocate for a safe transition home.

# Service worksheet



**Service Delivered**
- Care transition coaching X
- Case finding
- Refer to Behavioral health counseling X
- Engagement X
- Follow up X
- Transportation
- Meals
- Housing
- In home supports X
- Home safety evaluation X
- Logistical needs X
- Whole person needs assessment X
- Medication review, reconciliation, & delivery X
- EducationX
- Advocacy X
- Navigating X
- Peer support
- Crisis intervention
- Detox
- Motivational interviewing X
- Linkage to community services X
- Physician follow up X
- Adult Day Health

**Personnel Type**
- Hospital-based nurse X
- Hospital-based case manager X
- Hospital-based pharmacist X
- Hospital-based NP/APRN X
- Hospital-based behavioral health provider
- Hospital based psychiatrist
- Community-based nurse X
- Community-based social worker X
- Community-based pharmacist X
- Community agency X
- Physician
- Palliative care/Hospice
- Skilled nursing facilityX
- Acute-care Rehab
- Home health agencyX
- Other: Community care manager X
- Other: ____________________
- Other: ____________________
- Other: ____________________
- Other: ____________________

**Service Availability**
- 5 days/week
- Days

# Service mix



| Service | By Whom | For Whom | For How Long |
|---|---|---|---|
| Clinical coordination across providers & settings | Complex Care Team NP | For both TP's | 30 days |
| Social work, mobilization of resources, personal goals | Social Worker (ASAP) | For both TP's | 30 days |
| In-home "eyes & ears" of CCT | ASAP/readmission prevention nurse/NP/HHC | HU TP | 30 days |
| In-home medication review | Winchester Pharmacy | Once post discharge for both TP's | Once |
| Readmission reviews | CCT, PAC | For both TP's | At time of readmission for duration of program |

| | |
|---|---|
| **#FTE/units of service hired at my organization** | 0.8 NP (hire), 1.6 RN (hire), 0.6 pharmacist (hire),<br>• In kind, existing staff excluded from this list<br>Total = 3 FTE |
| **#FTE/units of service contracted** | 0.87 SW (new hire; ASAP work week is 35 hr/week) |

# List of service providers/community agencies

| Type of Service Provider | Community Agency Name | New or Existing Relationship |
|---|---|---|
| Elder Services | Minuteman Elder Services | New |
| Home Health Care | Winchester Home Care<br>VNA Middlesex<br>Medford VNA | Existing |
| Skilled Nursing Facilities | Salter Healthcare<br>Wingate<br>Woodbriar<br>Wilmington Healthcare Center<br>Bear Hill<br>Blueberry Hill<br>Meadow View | Existing |
| LTAC | Kindred<br>Spaulding | Existing |
| Hospice/Palliative Care | Care Dimensions | Existing |
| Behavioral Health | Lahey Health Behavioral Services | Existing |
| Community Pharmacy | Winchester Pharmacy | New |

# Summary of services – HU





## Clinical service and staffing mix

**Prior to presentation:**
1.Create flag in ED IS to identify HU
2.Create dashboard to capture HU population, % of patients served, services delivered, outcomes
3.Create a way for individual care plans to be viewable to CCT, PCPs and ED, and others

**Patient Identification/ Acute Care Presentation:**
1.Automatic flag in ED registration system to identify HU target population upon presentation to ED
2.CCT is automatically notified (paged, emailed, etc) that target population is in ED; CCT responds to ED <60m.
3. ED Doc reviews CCT care plan to assess need for admission, to prevent the readmission and collaborates with CCT

**Hospital-based Processes**
1.Pharmacy technician obtains medication list upon admission
2.Pharm tech and pharmacist conduct admission medication review and optimization
3.CCT reach out to any other programs patient is enrolled in (PACE, SCO) to optimize coordination of services.
4.CCT team conducts care rounds within 24 hours of admission [measure]
5.CCT team develops individual care plans in collaboration with patient, family/key support (learners) and relevant clinicians to articulate whole-person needs and the resources and services in place to address those needs (including referral to Joint Award BH program).
6.CCT will round routinely on this cohort of patients, will utilize the Care Dimensions liaison/or patient selected organization to facilitate consults for palliative and/or hospice care, will facilitate documentation of MOLST and Honoring Choices information
7.CCT SW establishes an ongoing relationship with each identified member of the target population.
8.CCT SW assesses gaps and barriers in care through interactions with patient and family, case managers and social workers.
9.CCT team introduces the Winchester Pharmacy community program which provides medication delivery, reconciliation, and education to patients in the community
10.Community SW initiates an in-person visits prior to patient discharge
11.CCT Pharmacist engages directly with patients and family/caregivers for medication counseling, including affordability
12.Pharmacist conducts discharge medication review
13.Unit secretary insures all follow up appointments with all relevant clinicians are made prior to discharge
14.CCT SW schedules follow up appointment to visit in home after discharge (within 3-5 days)

# Summary of services (1 of 2) – PAC

## Clinical service and staffing mix

**Prior to presentation:**

1.The admission source (PAC) will be identified so the ED/CHART staff are aware of patients coming in from SNFs etc.
2.Create dashboard to capture PAC target population, % of patients served, services delivered, outcomes
3.Create a way for individual care plans to be viewable to CCT, PAC provider, PCPs and ED, and others

**Patient Identification/ Acute Care Presentation:**

1.Automatic flag in ED registration system to identify PAC target population upon presentation to ED/inpatients being discharged to PAC.
2.CCT is automatically notified (paged, emailed, etc) that target population is in ED; CCT responds to ED <60m.
3. ED Doc reviews CCT care plan to assess need for admission, to prevent the readmission and collaborates with CCT
4. ED Doc to communicate with PAC facility for reason for ED visit (verbal collaboration initiated by SNF/PAC)

**Hospital-based Processes**

1.Pharmacy technician obtains medication list upon admission
2.Pharm tech and pharmacist conduct admission medication review and optimization
3.CCT reach out to any other programs patient is enrolled in (ACO, PACE, SCO) to optimize coordination of services.
4.CCT team develops individual care plans in collaboration with patient, family/key support (learners) and relevant clinicians to articulate whole-person needs and the resources and services in place to address those needs (including referral to Joint Award BH program).
5.CCT will round routinely on this cohort of patients, will utilize the Care Dimensions liaison/or patient selected organization to facilitate consults for palliative and/or hospice care, will facilitate documentation of MOLST and Honoring Choices information
6.CCT SW establishes an ongoing relationship with each identified member of the target population.
7.CCT SW assesses gaps and barriers in care through interactions with patient and family, case managers and social workers.
8.Community SW initiates an in-person visits prior to patient discharge
9.CCT Pharmacist engages directly with appropriate patients and family/caregivers for medication counseling, including affordability
10.Pharmacist conducts discharge medication review for appropriate patients
11.CCT RN will reach out to the PAC contact within 24-48 hours and/or if patient is high risk

# Summary of services (2 of 2) – PAC





## Clinical service and staffing mix

**Post-Hospital Transitional Care Services**

1.CCT makes follow up phone calls within 2 days of discharge
2.For patients not enrolled in Winchester Pharmacy program, CCT conducts in-home post discharge medication reconciliation/review (depending upon scope of provider), as needed and communicates with prescribers regarding medication changes discrepancies, and optimization recommendation.
3.CCT RN will assess the level of services for all patients being discharged and frequency of services once discharged
4.CCT will reassess patient at home <5 days of discharge and assists patient in the navigation of medical/mental health care system, reassesses patients periodically for the need to refer and link to hospice or palliative care, wound care, diabetes clinic, detox or behavioral health services and social agency supports needed (including referral to Joint Award BH services)
5.CCT collaborates on behalf of CCT with HC and SNF to ensure coordination, specifically managing post-SNF transitions.
6.CCT SW follows BRIDGE model of transitional care, connecting patient to financial or social services such as food, shelter and transportation, home care support, family support, support groups. SW calls patients at least weekly for 3 weeks to reassess needs over time.
7.CCT will reassess care plan to ensures that the individual care plan is updated and communicated to all relevant providers upon discharge from PAC to home.

# Cohort-wide standard measures – Hospital utilization measures





| Data elements | All | Target Population 1: High utilizers | Target Population 2: PAC |
|---|---|---|---|
| 1. Total Discharges from Inpatient Status (“IN”) | x | x | x |
| 2. Total Discharges from Observation Status (“OBS”) | | | |
| 3. SUM: Total Discharges from IN or OBS (“ANY BED”) | x | x | |
| 4. Total Number of Unique Patients Discharged from “IN” | | x | x |
| 5. Total Number of Unique Patients Discharged from “OBS” | | | |
| 6. Total Number of Unique Patients Discharged from “ANY BED” | | | |
| 7. Total number of 30-day Readmissions (“IN” to “IN”) | x | x | x |
| 8. Total number of 30-day Returns (“ANY BED” to “ANY BED”) | | | |
| 9. Total number of 30-day Returns to ED from “ANY BED” | x | x | |
| 10. Readmission rate ("IN readmissions" divided by "IN") | x | x | x |
| 11. Return rate (ANY 30-day Returns divided by “ANY BED”) | | | |

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

# Cohort-wide standard measures – ED utilization measures

| Data Elements | All | Target Population 1: High utilizers | Target Population 2: PAC |
|---|---|---|---|
| 12. Total number of ED visits | | | |
| 24a. Median ED LOS (time from arrival to departure, in minutes) | | | |
| 24b. Min ED LOS (time from arrival to departure, in minutes) | | | |
| 24c. Max ED LOS (time from arrival to departure, in minutes) | | | |
| 25a.Median ED LOS (time from arrival to departure, in minutes), primary BH diagnosis | | | |
| 25b. Min ED LOS (time from arrival to departure, in minutes), primary BH diagnosis | | | |
| 25c. Max ED LOS (time from arrival to departure, in minutes), primary BH diagnosis | | | |
| 26a. Median ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure) | | | |
| 26b. Min ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure) | | | |
| 26c. Max ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure) | | | |





Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

# Cohort-wide standard measures – Service delivery measures



| Data elements | Target Population 1: High utilizers | Target Population 2: PAC | Non-duplicated counts |
|---|---|---|---|
| 27. Total number of unique patients in the target population | x | x | x |
| 28. Number of acute encounters for target population patients | x | x | x |
| 29. For acute encounters in measure #28, number of these with any CHART service provided after discharge and within 48 hours | x | x | x |
| 30. Total number of contacts for the target population | x | x | x |
| 31. Average number of contacts per patient served | | | |
| 32a. Min number of contacts for patients served | x | x | |
| 32b. Max number of contacts for patients served | x | x | |
| 33. Number of units of service provided by service modality (including, e.g., phone call, virtual interaction, face to face in office, face to face in home, etc.) | x | x | |
| 34. Number of units of service provided, by service types (e.g., care coordination, medication optimization, clinical care, counseling, needs assessment, etc.) | x | x | |
| 35. Number of units of service provided, by role type (NP, LICSW, Pharmacist, Community Health Worker, Peer) | x | x | |
| 36. Average time (days, months) enrolled in CHART program per patient | | | |
| 37. Range time (days, months) enrolled in CHART program per patient | | | |
| 38. Proportion of target population patients with care plan | | | |



Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

# Cohort-wide standard measures – Payer mix

| Data elements | Medicare | Medicaid | Commercial |
|---|---|---|---|
| 39. Count of patients in the Target Population | x | x | x |





Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

# Program-specific measures – High utilizer

| Measure ID | Measure Description |
|---|---|
| H001 | Number of TP patients identified for whom there is a full six months of time passed following CHART eligibility |
| H002 | Total discharges for 6 months before CHART eligibility |
| H003 | Total 30-day readmissions for 6 months before CHART eligibility |
| H004 | Total ED visits for 6 months before CHART eligibility |
| H005 | Total 30-day ED revisits for 6 months before CHART eligibility |
| H006 | Total discharges for 6 months starting on and inclusive of the date of CHART eligibility |
| H007 | Total 30-day readmissions for 6 months starting on and inclusive of the date of CHART eligibility |
| H008 | Total ED visits for 6 months starting on and inclusive of the date of CHART eligibility |
| H009 | Total 30-day ED revisits for 6 months starting on and inclusive of the date of CHART eligibility |
| H010 | Total months following CHART eligibility without exit event |





Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

# Program-specific measures with HPC specifications



| Data Elements | Numerator | Denominator |
|---|---|---|
| Total Discharges to SNF (PAC TP) | Count of the number of IN discharges for the target population that were discharged to a skilled nursing facility | N/A |
| Total Discharges to Home Health (PAC TP) | Count of the number of IN discharges for the target population that were discharged to home health | N/A |
| Total Discharges to Home (PAC TP) | Count of the number of IN discharges for the target population that were discharged to home | N/A |

# Program-specific measures (1 of 2)

| Data Elements | Numerator | Denominator |
|---|---|---|
| # inpatient consults to inpt pharmacists | # inpt pharm consults | # pts seen by CCT |
| # med profile reviews by inpt pharmacist | # inpt med profiles reviewed | # inpt CCT pharm consults |
| # inpatient clinical interventions by inpt pharmacists | # clinical interventions by inpt pharmacists | # inpt med profiles reviewed (of CCT pts) |
| # education sessions done by inpt. pharmacist | # education sessions done by inpt pharm | # inpt med profiles reviewed (of CCT pts) |
| # of PAC patients evaluated in ED and discharged from ED back to PAC (SNF, LTAC, HC (?)) | Pts discharged back to PAC | all PAC patients evaluated in the ED (SNF, LTACT, HC) |
| # pts CCT conducts rounds on within 24 hours | #pts CCT did rounds on within 24 hours of admission | #pts identified for CCT |
| # of palliative care consults | #pts receiving palliative care consult | # pts seen by CCT |
| # hospice referrals | # pts receiving hospice consult | # pts seen by CCT |
| # pts referred to BH services (joint program) | # pts referred to BH services | # pts seen by CCT |
| # pts from CCT discharged to home with no services | # pts discharged home with no home care | # CCT pts discharged |

# Program-specific measures (2 of 2)

| Data Elements | Numerator | Denominator |
| --- | --- | --- |
| # pts refusing post discharge follow up by CCT | # pts refusing post d/c follow up | # CCT pts discharged |
| # pts from CCT discharged to home with no services | # CCT pts discharged | # pts discharged home with no home care |

# Continuous improvement plan (part 1 of 2)



| | |
|---|---|
| **1. How will the team share data? Describe.** | Team will initially meet biweekly to review progress and then move to monthly review if appropriate |
| **2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.** | The PM will review data weekly and will submit to the Investment Directors bi-weekly initially then move to monthly if appropriate |
| **3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.** | The CHART 2 steering committee (including VPs) will meet every other week and will review metrics. |
| **4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.** | Weekly |
| **5. How often will your community partners review data (e.g., weekly, monthly)? Describe.** | Depending upon agency, may be weekly to monthly. |
| **6. Which community partners will look at CHART data (specific providers and agencies)? Describe.** | CHART data will be reviewed with community partners (SNFs, PCPs, Home Care,); direct access to the data will be dependent upon relationship with partner. |
| **7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.** | PM will report to quality board quarterly. |

# Continuous improvement plan (part 2 of 2)



| | | |
|---|---|---|
| **8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)? Describe.** | **Cohort-Wide** | **Program specific** |
| | Data analyst & finance | Data analyst & finance |
| **9. What is your approximate level of effort to collect these metrics? Describe.** | **Cohort-Wide** | **Program specific** |
| | Once reports are written (moderate effort), the reporting will be automatic | Once reports are written, the reporting will be automatic |
| **10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.** | Our IS, Quality, & finance departments are working together closely to insure what we want to measure is possible | |
| **11. How will you know when to make a change in your service model or operational tactics? Describe.** | Close monitoring of our data will direct our changes. | |
| **12. Other details:** | | |

# Enabling technologies plan

| Functionality | User | Vendor | Cost |
|---|---|---|---|
| Secure text paging | Complex care team | CoreText | $750 |
| ADT feed (for core text and technology platform) | Complex care team | TBD | $5,000 |
| Task management/tracking of metrics/central repository for outpatient care provided | Complex Care team | Loopback Analytics | $28,276 (CHART-funded portion) |
| Reports to pull patient demographics – includes 25 reports plus a dashboard | Complex Care team | AcmeWare – One View | $44,250 |

# Enabling technology: Q&A

**How are you going to identify target population patients in real-time?**

– Patients will be identified on the ED bed tracker and via a real time dashboard accessed by the complex care team. This is created and is being fine tuned based on needs and feedback of team.

**How will you measure what services were delivered by what staff?**

– Being discussed; we are trying to include as much of this as possible as structured data so reports can be run out of Meditech. Task/metrics after discharge to be tracked by new technology

**How will you measure outcome measures monthly?**

– Meditech reports built by Acmewear; new technology for outpatient metrics

**What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care**?

– Loopback

**Where will individual care plans reside, and what is the plan for making them available on a need-to-know basis 24/7 in the ED, hospital, and ambulatory settings?**

– Care plans reside in Meditech and are available to anyone with Meditech access (on site or remote) 24/7. The format, fields and data captured on these care plans are being evaluated

**Do you have a method for identifying what clinical services your target population accesses?**

– Loopback

## Other essential investments

| Other investment | Budget Required |
|---|---|
| Community Social Worker | $149,408 |
| Laptop computers for 5 staff supporting care management and complex care teams | $10,000 |

# Key dates

| Key milestone | Date |
|---|---|
| **Launch date (beginning of your 24 month Measurement Period)** | 11/1/15 |
| Post jobs | 9/21/15 |
| New hires made | 10/19/15 |
| Execute contracts with service delivery partners | 9/25/15 |
| Execute contract with Loopback | 9/25/15 |
| Initiatives support 50% of planned patient capacity | 11/1/15 |
| Initiatives support 100% of planned patient capacity | 1/1/16 |
| First test report of required measures | 10/15/15 |
| Enabling technology – Loopback testing initiated | 9/28/15 |
| Enabling technology – Loopback go-live | 11/1/15 |
| Trainings completed – Meditech, Loopback, Workflow<br>Hospital orientation – new hires have two days of hosp orientation can take 90 days to complete | 10/30/15<br>12/30/15 |
| First patient seen | 11/1/15 |

# Community partners/subcontractors

| Name | Business Address | Website | Contact Name | Contact Title | Contact Phone Number | Contact Email Address |
|---|---|---|---|---|---|---|
| Minuteman Elder Services | 26 Crosby Dr, Bedford, MA 01730 | www.minutemansenior.org | Joan Butler | Executive Director | Phone: (888) 222-6171<br>Fax: (781) 229-6190 | J.Butler@minutemansenior.org |
| AcmeWare – OneView | 333 Elm Street Suite 225 Dedham, MA 02026 | http://www.acmeware.com/products.aspx | Geoff Grouten | Manager, Consultant Analysts | (781) 329-4300 x201 | |
| Loopback Analytics | 14900 Landmark Blvd, Ste. 240 Dallas, TX 75254 | www.loopbackanalytics.com | Melissa Rowley | Director, Business Development | 312-485-9923 | mrowley@loopbackanalytics.com |
| ADT feed - TBD | | | | | | |